Evidence of Coverage

Effective January 1, 2025 – December 31, 2025

PERS *Gold*

Supplement to Original Medicare Plan

Preferred Provider Organization (PPO)

A Self-Funded Medicare Health Plan Administered
by the CalPERS Board of Administration under the
Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

We have included a Summary of Covered Services for the PERS Gold Supplement to Original Medicare Plan with a comprehensive description following. It will be to your advantage to familiarize yourself with this booklet before you need services.

Take time to review this booklet. The information contained will be useful throughout the year.

NOTICE

This Benefit Booklet describes the terms and conditions of coverage of your health plan.

Please read this Benefit Booklet carefully and completely so that you understand which services are covered health care services, and the limitations and exclusions that apply to your plan. If you or your dependents have special health care needs, you should read carefully those sections of the booklet that apply to those needs.

If you have questions about the benefits to your plan, or if you would like additional information, please contact Member Services at the address or telephone number listed on the back cover of this booklet.

PLEASE NOTE

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor or clinic, or call the health plan at the Member Services telephone number listed at the back of this booklet to ensure that you can obtain the health care services that you need.

This Benefit Booklet constitutes only a summary of the PERS Gold Supplement to Original Medicare PPO Health Plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. However, the statement of benefits, exclusions and limitations in this Benefit Booklet is complete and is incorporated by reference into the contract.

The Plan Document is on file and available for review in the office of the CalPERS Health Plan Research and Administration Division, 400 Q Street, Sacramento, CA 95811, or P.O. Box 720724, Sacramento, CA 94229-0724. You may purchase a copy of the Plan Document from the CalPERS Health Plan Research and Administration Division for a reasonable duplicating charge.

Notice about this Administrative Services Only plan: CalPERS is the Employer. Blue Shield of California has been appointed the Claims Administrator. Blue Shield of California processes and reviews the claims submitted under this Plan.

Blue Shield of California provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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Benefit and Administrative Changes

The following is a brief summary of administrative changes that will take effect January 1, 2025.

- There are no benefit changes for 2025.

THIS IS ONLY A BRIEF SUMMARY. REFER TO THE BENEFIT DESCRIPTIONS AND LIMITATIONS IN THIS BOOK FOR FURTHER INFORMATION.

Summary of Covered Services

Category Description	Coverage & Limitations	
	Medicare Pays	**Member Pays***
Hospital		
Inpatient**	See Medicare Handbook	No Charge (if Medicare approved)
Outpatient**	See Medicare Handbook	No Charge (if Medicare approved)
Physician Services**		
Office/Home/Hospital Visits	See Medicare Handbook	No Charge (if Medicare approved)
Allergy Testing/Treatment	See Medicare Handbook	No Charge (if Medicare approved)
Acupuncture Benefits 20 visits per Calendar Year, combined with Chiropractic Benefits	See Medicare Handbook	No Charge (if Medicare approved)†
Chiropractic Benefits 20 visits per Calendar Year, combined with Acupuncture Benefits	See Medicare Handbook	No Charge (if Medicare approved)†
Christian Science Treatment 24 sessions per Calendar Year	See Medicare Handbook	20% of Blue Shield of California's Allowable Amount†
Blood All but the first three pints per Calendar Year	See Medicare Handbook	No Charge (if Medicare approved)
Diabetes services**		
Glucose monitors, test strips, lancets, etc.	See Medicare Handbook	No Charge (if Medicare approved)
Diabetes self-management training	See Medicare Handbook	No Charge (if Medicare approved)
Preventive Services		
Gynecological exam (Pap test)	See Medicare Handbook	No Charge (if Medicare approved)
Immunization/Inoculation	See Medicare Handbook	No Charge (if Medicare approved)
Diagnostic X-ray/Lab	See Medicare Handbook	No Charge (if Medicare approved)
Durable Medical Equipment** (including Orthoses and Prostheses)	See Medicare Handbook	No Charge (if Medicare approved)

Summary of Covered Services

Hearing Aid services The hearing aid (monaural or binaural), including ear mold(s), the hearing aid instrument, initial batter cords, and other ancillary equipment, is subject to a maximum payment of $1,000 per Member once every 36 months.	See Medicare Handbook	20% of Blue Shield of California's Allowable Amount†
Ambulance Services	See Medicare Handbook	No Charge (if Medicare approved)
Emergency Care/Services Under certain conditions, Medicare helps pay for emergency outpatient care provided by Non-Participating Hospitals.	See Medicare Handbook	No Charge (if Medicare approved)
Home Health Services	See Medicare Handbook	No Charge (if Medicare approved)
Physical/Occupational/Speech Therapy	See Medicare Handbook	No Charge (if Medicare approved)
Skilled Nursing Care** Up to 100 days per calendar year	See Medicare Handbook	No Charge (if Medicare approved)
Smoking Cessation Program Up to $100 per Calendar Year for behavior modifying smoking cessation counseling or classes or alternative treatments, such as acupuncture or biofeedback, for the treatment of nicotine dependency or tobacco use.	See Medicare Handbook	20% of Blue Shield of California's Allowable Amount†
Hospice	See Medicare Handbook	No Charge (if Medicare approved)
Mental Health May include treatment of substance use disorders if Medicare-approved		
Inpatient	See Medicare Handbook	No Charge (if Medicare approved)
Outpatient	See Medicare Handbook	No Charge (if Medicare approved. Medicare pays 50% of the approved amount for most services)
Vision Care One exam and two lenses per Calendar Year One set of frames every 24 months **Maximum allowance** Exam……………………...$35 Frames……………………$30 Each lens: Single vision…………..$20	Not covered by Medicare	Any amount in excess of the maximum allowance

Bifocal………………...$35 Trifocal……………….$45 Lenticular……………..$50 Contact lenses…………....$100		

* Important Note: The term "No Charge" above applies when benefits are payable by Medicare and you use a provider who accepts Medicare assignment (i.e. Covered Services will be paid in full). However, if you use a provider who does not accept Medicare assignment, you may be responsible for balances remaining after payment has been made by the PERS Gold Supplemental Plan. See the "Paying for Covered Services" and "Claims" sections for important information regarding Plan payments.

† For this service, a Benefit Beyond Medicare is also available. Please see the "Benefits Beyond Medicare" section of this booklet for details. In brief, in the specified situation, when Benefits are not covered by Medicare or Medicare's benefits have been exhausted, the Plan will pay 80% of the Allowable Amount if you use a Medicare Provider. However, if you use a Non-Preferred Provider, the Plan will pay 80% of the Allowable Amount as determined by Blue Shield of Cali-fornia, and your responsibility will be 20% of the Allowable Amount plus any charges in excess of the Allowable Amount. See the "Paying for Covered Services" and "Claims" sections for important information regarding Plan payments.

** For Members who are eligible, services and certain Drugs may be covered as described in your Medicare Part D Prescription Drug Plan Evidence of Coverage booklet, administered by Optum Rx®.

Your Introduction to the PERS Gold Supplement to Original Medicare PPO Health Plan

Welcome to your PERS Gold Supplement to Original Medicare Plan. If you choose to get care from a provider who does not participate in the Medicare program, Medicare and this Plan will not pay for the services and supplies provided by that provider. You will have to pay whatever the provider charges you for his or her services. (For information on Medicare benefits, please refer to the *Medicare & You* handbook or call your nearest Social Security office.)

This PERS Gold Supplement to Original Medicare Plan is designed for Members enrolled in the California Public Employees' Retirement System's (CalPERS) health benefits program who are also enrolled in both Parts A (hospital insurance) and B (medical insurance) of Medicare. This Plan is in addition to a Medicare Part D Plan administered by Optum Rx® and described in a separate EOC. Medicare Part A is hospital insurance that helps cover inpatient care in Hospitals, Skilled Nursing Facilities, and Hospices, in addition to home health care. Medicare Part B helps cover Preventive Health Services and Medically Necessary services like doctors' visits, outpatient care, home health services, and other medical services. Check your Medicare card to find out if you have Part B. Medicare Part D covers prescription drugs and is administered by Optum Rx®. You are not allowed to enroll in a Part D prescription drug plan that is not part of a CalPERS approved health benefit plan and remain enrolled in the PERS Gold Supplement to Original Medicare Plan. If you choose to opt out of the Gold Medicare Part D Prescription Drug Plan, administered by Optum Rx®, you will lose your Medicare Part D prescription Drug coverage, and you will be responsible for all of your prescription Drug costs.

After you or your eligible family members are enrolled in this Plan, you may not change enrollment to a Basic Plan unless (1) there is an involuntary termination of your Medicare benefits, or (2) you move, other than temporarily, outside the United States as defined in the Federal Social Security Act. If you voluntarily cancel Part B of Medicare, you will not be eligible for a Basic Plan, nor will you be allowed to remain in this Plan.

A family group member, including a person enrolled in this PERS Gold Supplement to Original Medicare Plan, who is not eligible for Medicare and continues in the Gold Basic PPO Plan must enroll in this Plan when he or she is eligible to enroll in Medicare.

A Notice of Creditable Coverage documents your coverage under the PERS Gold Supplement to Original Medicare Plan. However, you should be aware that, if you have a subsequent break in this coverage of 63 days or more before enrolling in Part D, you could be subject to payment of higher Part D premiums. You may request a copy of a Notice of Creditable Coverage by calling the Member Services Department at 800-405-2127.

Please note that this Plan does not cover Custodial Care in any facility or situation, including a Skilled Nursing Facility.

As a PERS Gold Supplement to Original Medicare Plan Member, you are responsible for meeting the requirements of the PERS Gold Supplement to Original Medicare Plan. Lack of knowledge of, or lack of familiarity with, the information contained in this Evidence of Coverage booklet does not serve as a reason for noncompliance. Please take the time to familiarize yourself with this booklet and *Medicare & You*.

The term "Member" is used throughout this booklet to mean employees or retirees and their family members and/or domestic partners who are enrolled in this PPO Plan through CalPERS.

Your Introduction to the PERS Gold Supplement to Original Medicare PPO Health Plan

IMPORTANT

If you have questions about your benefits, contact Blue Shield of California before hospital or medical services are received.

If you have any questions regarding the information, you may contact us through our Member Services Department at 800-405-2127. The hearing impaired may contact the Member Services Department through the Blue Shield of California's toll-free text telephone (TTY) number, 711.

Medicare & You

Each year the U.S. Department of Health and Human Services publishes a Medicare handbook entitled Medicare & You. This handbook outlines the benefits Medicare provides and includes any changes in deductibles, coinsurance, or benefits that may occur from year to year. To obtain a copy, contact your nearest Social Security office, visit the Web site www.medicare.gov, call 1-800-MEDICARE or write to:

Medicare Publications
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

A directory of Physicians who accept Medicare assignment (Medicare Provider Directory) can also be obtained from the Department of Health and Human Services at the above address.

Please refer to the "Paying for Covered Services" section below for a description of the difference in benefit payments using a provider who accepts Medicare assignment and a provider who does not accept Medicare assignment. It is your responsibility to confirm with your provider whether or not he or she accepts Medicare assignment prior to receiving services.

Some providers do not participate in Medicare. If you choose to get care from a provider who has decided not to participate in, or has been excluded from, the Medicare program, Medicare and this Plan will not pay for services provided by that provider. You will have to pay whatever the provider charges you for his or her services.

Claim-Free Service

As a PERS Gold Supplement to Original Medicare Plan Member, you may enroll in a claims filing program called the Claim-Free program. Your enrollment in the Claim-Free program means that you need not file a paper claim yourself for Supplement to Original Medicare professional and hospital benefits as long as your provider billed Medicare directly.

NOTE: The Claim-Free program does not apply to the Benefits in the "Benefits Beyond Medicare" section. See the "Claims" section for more information on how to obtain reimbursement for those Benefits.

Once enrolled in the Claim-Free program, your Supplement to Original Medicare benefits will automatically be paid through Blue Shield of California's Claim-Free process, which makes it possible for plans to electronically obtain Medicare claims data directly from Medicare claims processors.

To enroll in the Claim-Free program, return the postcard that will be sent to you automatically once you are enrolled in the PERS Gold Supplement to Original Medicare Plan. You may also call Blue Shield of California at 800-405-2127 to enroll. Please make sure you have your Medicare card available when you place the call.

You may disenroll from the Claim-Free program for any reason by calling Blue Shield of California at 800-405-2127. Make sure you have your Medicare card available when you place the call. If you choose to disenroll in the Claim-Free program, you will need to submit your claims to Medicare as discussed on the next page.

Supplement to Original Medicare Benefits

Subject to benefits being covered by Medicare while you are enrolled under the PERS Gold Supplement to Original Medicare Plan, Plan will pay the amounts shown below under Plan Payments for Medically

Necessary services and supplies furnished for the diagnosis or treatment of illness, pregnancy, or Accidental Injury. The date on which a service or supply is furnished will be deemed the date on which the expense was incurred or the charge made.

If you choose to get care from a provider who does not participate in the Medicare program, Medicare and this Plan will not pay for the services and supplies provided by that provider. You will have to pay whatever the provider charges you for his or her services. (For information on Medicare benefits, please refer to the Medicare & You handbook or call your nearest Social Security office.)

Hospital Benefits (Part A)

If you are not enrolled in the Claim-Free program, you should present your PERS Gold Supplement to Original Medicare Plan ID card along with your Social Security Medicare ID card at the hospital admissions desk. The hospital may bill Blue Shield of California for Benefits under your PERS Gold Supplement to Original Medicare Plan after they have received payment from Medicare. You should discuss billing procedures with the hospital's billing office.

If you do not have your PERS Gold Supplement to Original Medicare Plan ID card when you enter the Hospital or if the status of your contract is questioned, ask the hospital to contact Blue Shield of California at 800-405-2127.

Medical Benefits (Part B)

If you are not enrolled in the Claim-Free program, you must first submit all medical claims to Medicare.

After Medicare has processed your claim, you will receive a Medicare Summary Notice statement. Write your member number and group number (from your PERS Gold Supplement to Original Medicare Plan ID card) on the Medicare Summary Notice statement, and then mail it and a copy of the itemized bill for the services received to:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927

Prescription Drug Benefits (Part D)

If you are enrolled in one of our Medicare Part D Prescription Drug Plans, administered by Optum Rx®, refer to your Medicare Part D Prescription Drug Coverage EOC or contact:

Optum Rx® Member Services
P.O. Box 3410
Lisle, IL 60532
1-855-505-8106

The PERS Gold Supplement to Original Medicare Plan will make supplemental payments as described below.

Payments for services covered by this Plan may be paid to you or directly to the provider, if he or she is a Medicare Provider.

Paying for Covered Services

When a Member is receiving concurrent benefits from Medicare, the PERS Gold Supplement to Original Medicare Plan pays 100% of the Medicare Part A and B deductibles.

Plan Payments

When a Member is receiving concurrent benefits from Medicare, the PERS Gold Supplement to Original Medicare Plan payments for Covered Services are provided according to whether the provider participates in the Medicare program and accepts Medicare assignment or not.

- If the provider participates in Medicare and accepts Medicare assignment:
    - The PERS Gold Supplement to Original Medicare Plan payment is limited to 100% of the difference between the amount paid by Medicare and Medicare's approved amount. See notes 1 and 2 below.
- If the provider participates in Medicare and DOES NOT accept Medicare assignment:
    - The PERS Gold Supplement to Original Medicare Plan payment is limited to 100% of the Medicare Limiting Amount less the amount paid by Medicare for Covered Services. See notes 1 and 3 below.
- If the provider DOES NOT participate in Medicare:
    - Medicare and this Plan do not pay. The total provider charges are the Member's responsibility to pay. See note 4 below.

Notes:

1. With regard to professional services and supplies, the PERS Gold Supplement to Original Medicare Plan payment plus the Medicare payment will be accepted as payment in full by Medicare providers. Whether they accept Medicare assignment or not, Medicare providers will not bill Members for amounts exceeding Medicare's approved amount. Members remain responsible for charges for services and supplies that are not covered by Medicare or the PERS Gold Supplement to Original Medicare Plan.

2. With regard to professional services and supplies, the PERS Gold Supplement to Original Medicare Plan plus the Medicare payment will be accepted as payment in full by providers who are not Medicare providers but who DO accept Medicare assignment. Such providers may not bill Members for charges in excess of Medicare's approved amount. Members remain responsible for charges for services and supplies that are not covered by Medicare or the PERS Gold Supplement to Original Medicare Plan.

3. With regard to professional services and supplies, Members are responsible for any difference between the combined amount paid by the PERS Gold Supplement to Original Medicare Plan and Medicare and the charges billed by providers who are not Medicare providers and who do not accept Medicare assignment, within the limits of applicable law. Such providers may bill Members for the balance of any unpaid charges and for services and supplies that are not covered by Medicare or the PERS Gold Supplement to Original Medicare Plan.

4. Some providers do not participate in Medicare. Members will be responsible for the total charges billed by providers who do not participate in the Medicare program.

Eligibility and Enrollment

Information pertaining to eligibility, enrollment, and termination of coverage, can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer or, if you are retired, the CalPERS Health Account Management Division at:

CalPERS
Health Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715
Or call:
888 CalPERS (or **888**-225-7377)
(916) 795-3240 (TDD)

Live/Work

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS employer and are no longer working for any employer, you must select a health plan using your residential ZIP Code.

SilverSneakers®

SilverSneakers is your fitness benefit, provided for you with no copayment. The program includes access to 13,000+ fitness locations* nationwide, exercise equipment and other amenities, a support network, online resources and group exercise classes led by certified instructors.

SilverSneakers currently offers the following classes. You can find the full class descriptions at **silver-sneakers.com**.

a. **Signature SilverSneakers classes** designed for all levels and abilities are offered in traditional fitness classrooms inside the gym.
b. More than 70 **SilverSneakers FLEX®** class options including Latin dance, yoga, tai chi and walking groups are offered in settings outside the traditional gym.
c. Three **BOOM®** classes, MIND, MUSCLE and MOVE IT, offer more intense workouts inside the gym. The 30-minute classes can be modified to fit individual participants' comfort levels.

To start using the program, simply show your personal SilverSneakers ID number at the front desk of any participating location. You may get your SilverSneakers ID number and find fitness locations and classes at **silversneakers.com**. If you have additional questions about the program, call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET.

When you go to the fitness location of your choice, the staff will assist you with enrolling. You may also ask for a tour of the location to see all the amenities and where the classrooms are located. You may use any participating fitness location in the nation.

*At-home kits are offered for Members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.

NurseHelp 24/7

If you are unsure about what care you need, you should contact your physician's office. In addition, your Plan includes a service, NurseHelp 24/7, which provides licensed health care professionals available to assist you by telephone 24 hours a day, 7 days a week. You can call NurseHelp 24/7 for immediate answers to your health questions. Registered nurses are available 24 hours a day to answer any of your health questions, including concerns about:

1. Symptoms you are experiencing, including whether you need emergency care;
2. Minor illnesses and injuries;
3. Chronic conditions;
4. Medical tests and medications;
5. Preventive care.

If your physician's office is closed, just call NurseHelp 24/7 at 1-877-304-0504. (If you are hearing impaired dial 711 for the relay service in California.) The telephone number is listed on your Member identification card.

NurseHelp 24/7 programs provide Members with no charge, confidential telephone support for information, consultations, and referrals for health and psychosocial issues. Members may obtain these services by calling a 24-hour, toll-free telephone number. There is no charge for these services.

Condition Care

Your Plan includes Condition Care to help you better understand and manage specific chronic health conditions and improve your overall quality of life. Condition Care provides you with current and accurate data about asthma, diabetes, heart disease, and vascular-at-risk conditions plus education to help you better manage and monitor your condition. Condition Care also provides depression screening.

You may be identified for participation through paid claims history, hospital discharge reports, physician referral, or case management, or you may request to participate by calling Member Services at 800-405-2127. Participation is voluntary and confidential. These programs are available at no cost to you. Once identified as a potential participant, a Condition Care representative will contact you. If you choose to participate, a program to meet your specific needs will be designed. A team of health professionals will work with you to assess your individual needs, identify lifestyle issues, and support behavioral changes that can help resolve these issues. Your program may include:

- Mailing of educational materials outlining positive steps you can take to improve your health; and/or
- Phone calls from a nurse or other health professional to coach you through self-management of your condition and to answer questions.

Condition Care offers you assistance and support in improving your overall health. It is not a substitute for your Physician's care.

Teladoc

Teladoc provides health consultations by phone or secure online video. Teladoc general medical Physicians can diagnose and treat basic non-emergency medical conditions, and can also prescribe certain medication. Teladoc is a supplemental service that is not intended to replace care from your Physician. You do not need to contact your Physician before using the Teladoc service.

If your Physician's office is closed or you need quick access to a physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit blueshieldca.com/teladoc. The Teladoc physician can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications.

Teladoc physicians do not issue prescriptions for substances controlled by the DEA, non-therapeutic, and/or certain other drugs which may be harmful because of potential for substance use disorder.

How to Access Teladoc	
Teladoc Service	Availability
General medical	24 hours a day, 7 days a week by phone or secure online video Consultations can be requested on-demand or by scheduled appointment

Teladoc service is not available for Mental Health and Substance Use Disorder services consultations.

Copayment: $0 per consultation. If medications are prescribed, the applicable prescription drug copayments apply.

Retail-Based Health Clinics

Retail-based health clinics are conveniently located within stores and pharmacies. They are staffed with nurse practitioners who can provide basic medical care on a walk-in basis.

The Cost Share for Covered Services at a Participating retail-based health clinic is the same as the Cost Share at your Physician's office.

Emergency Services

An emergency means an unexpected medical condition, including a psychiatric Emergency Medical Condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a layperson who possesses an average knowledge of health and medicine could reasonably assume that the absence of immediate medical attention could be expected to result in any of the following: (1) placing the Member's health in serious jeopardy, (2) serious impairment to bodily functions, (3) serious dysfunction of any bodily organ or part. If you receive non-authorized services in a situation that Blue Shield of California determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those services.

Members who reasonably believe that they have an emergency medical or mental health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available.

What to do in case of Emergency:

Life Threatening

Obtain care immediately.

Contact your Chosen Physician no later than 24 hours after the onset of the emergency, or as soon as it is medically possible for the Member to provide notice.

Non-Life Threatening

Consult your Chosen Physician, anytime day or night, regardless of where you are prior to receiving medical care.

Follow-Up Care

Follow-up care, which is any care provided after the initial emergency room visit, must be provided or authorized by your Chosen Physician.

Urgent care centers

Urgent care centers are free-standing facilities that provide many of the same basic medical services as a doctor's office, often with extended hours but similar Cost Share.

If your condition is not an emergency, but you need treatment that cannot be delayed, you can visit an urgent care center to receive care that is typically faster and costs less than an emergency room visit.

How to Use the Plan

Limitation of Liability

Members shall not be responsible to Medicare Providers or health professionals who are Non-Preferred Providers rendering Services at a Medicare Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings) for payment for services if they are a benefit of the Plan, unless the Non-Preferred Provider provides the Member with written notice of what they may charge and the Member consents to those terms. When Covered Services are rendered by a Medicare Provider or rendered by a health professional who is a Non-Preferred Provider at a Medicare Provider facility, the Member is responsible only for the applicable copayments, except as set forth in the Third Party Recovery Process and the Member's Responsibility section. Members will not be responsible for additional charges above the Allowable Amount without written notice and consent. Members are responsible for the full charges for any non-covered services they obtain.

Member Identification Card

You will receive your PERS Gold Supplemental Plan ID after enrollment. If you do not receive your identification card or if you need to obtain medical services before your card arrives, contact the Blue Shield Member Services Department so that they can coordinate your care and direct your physician.

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield of California will have the right to recover such payment from the Participant or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. With notice, Blue Shield of California reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Participant or Member (copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Participant or Member's eligibility, or payments on fraudulent claims.

Member Services Department

For all services other than Mental Health and Substance Use Disorder

If you have a question about services, providers, benefits, how to use this plan, or concerns regarding the quality of care or access to care that you have experienced, you should call the Member Services Department at 800-405-2127. The hearing impaired may contact Blue Shield of California's Member Services Department through Blue Shield of California's toll-free TTY number, 711. Member Services can answer many questions over the telephone.

Expedited Decision

Blue Shield of California has established a procedure for our Members to request an expedited decision (including those regarding grievances). A Member, physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield of California shall make a decision and notify the Participant and physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other health care services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Member Services Department at 800-405-2127.

Benefits Beyond Medicare

The PERS Gold Supplemental Plan will provide the following coverage for Medically Necessary services and supplies when a Plan Member's benefits under Medicare are exhausted, or when charges for the services and supplies outlined in this section exceed amounts covered by Medicare.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

A. Acupuncture Benefits

Benefits are provided for routine acupuncture services up to the maximum visits per Calendar Year as shown below. Services include a patient history visit, physical examination, treatment planning and evaluation, electro acupuncture, cupping, moxibustion or other services. Plan Members are responsible for a $15 Copayment when the Benefits under Medicare are exhausted, any charges in excess of the Allowable Amount for covered services received from Non-Preferred Providers, plus all charges for non-covered services, subject to a combined maximum payment of twenty (20) visits per Calendar Year.

No Charge (if Medicare approved)
Any charges in excess of the Allowable Amount from a Non-Preferred Provider.

Covered up to a combined Benefit maximum of 20 visits with Chiropractic Benefits Covered Services.

B. Chiropractic Benefits

Chiropractic services are covered when provided by a Health Care Provider to treat disease, illness, or injury. Services include manipulation of the spine, joints, and/or musculoskeletal soft tissue, re-evaluation, or other services. Benefits are provided up to the maximum visits per Calendar Year as shown below. Plan Members are responsible for a $15 Copayment when the Benefits under Medicare are exhausted, any charges in excess of the Allowable Amount for covered services received from Non-Preferred Providers, plus all charges for non-covered services, subject to a combined maximum payment of twenty (20) visits per Calendar Year.

No Charge (if Medicare approved)
Any charges in excess of the Allowable Amount from a Non-Preferred Provider.

Covered up to a combined Benefit maximum of 20 visits with Acupuncture Benefits Covered Services.

C. Hearing Aid Services

Covered Services include an audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

80% Medicare Provider or Non-Preferred Provider for an audiological evaluation. Evaluation is in addition to the $1,000 maximum allowed every 36 months for both ears for the hearing aid and ancillary equipment.

Hearing Aid. Monaural or binaural including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, repairs, etc. at no charge for a 1-year period following the provision of a covered hearing aid.

Excludes the purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss. Excludes replacement parts for hearing aids, repair of hearing aid after the covered 1-year warranty period and replacement of a hearing aid more than once in any period of 36 months. Also excludes surgically implanted hearing devices. Cochlear implants are not considered surgically implanted hearing devices and are covered as a prosthetic rather than a hearing aid.

Limitations: Maximum payment will not exceed $1,000 per Member for both ears for the hearing aid instrument, and ancillary equipment.

D. Smoking Cessation

The PERS Gold Supplement to Original Medicare Plan provides Benefits for covered smoking cessation programs at 80% of the Allowable Amount.

Smoking cessation programs include behavior modifying smoking cessation counseling or classes or alternative treatments, such as acupuncture or biofeedback, for the treatment of nicotine dependency or tobacco use. The Plan provides payment of up to $100 per Calendar Year. A legible copy of dated receipts for expenses must be submitted along with a claim form to Blue Shield of California to obtain reimbursement.

E. Christian Science Treatment

Outpatient treatment for a covered illness or injury through prayer is payable when services are provided by a Christian Science Nurse, Christian Science Nursing Facility, or Christian Science Practitioner. This Benefit includes treatment in absentia (Christian Science Practitioners or nurses providing services, such as consultation or prayer, via the telephone).

No payment will be made for overnight stays in a Christian Science Nursing Facility.

80% Medicare Provider or Non-Preferred Provider. Benefits are limited to 24 sessions per person per Calendar Year.

Vision Care

Your routine vision care Benefits are administered by the Vison Plan Administrator (VPA). To receive maximum Benefits under this plan, make sure your vision care provider is a VPA Participating Provider. VPA Participating Providers will obtain prior authorization on your behalf and will submit claims to the VPA after you have received services.

You are not restricted to using VPA Participating Providers. If you choose to receive services from a Non-Preferred Provider, you must pay the bill at the time you receive the services and then request reimbursement from the VPA.

Vision Care Benefits

The vision care Benefits described below are provided for routine vision care only. Examples of Covered Services that are not considered routine include examinations for diagnosed medical conditions of the eye such as cataracts or glaucoma, and eyeglasses or contact lenses prescribed following cataract surgery.

To obtain reimbursement for the treatment of such non-routine medical conditions of the eye. You must first submit copies of your bills to Medicare for processing. After Medicare has paid its portion of the bill, submit a copy of the bill along with a copy of your Medicare Summary Notice to Blue Shield of California.

Once each Calendar Year, you may have an eye examination for refractive error, including refraction, examination of the inner eye, measurement of eye tension, routine testing for visual field, and muscle balance. If normal examination reveals the need, a complete visual field examination, including pupil dilation or muscle balance, will be allowed. A follow-up visit for muscle balance will also be covered if Medically Necessary.

1. Contact Lenses

When the Member chooses contact lenses instead of other eyewear, the Plan provides payment up to only the combined allowance for frames and lenses specified below, but not to exceed $100. The Plan will also pay a maximum of $100 toward the purchase of contact lenses when Medically Necessary following cataract surgery, or if they are the only means by which vision in the better eye can be corrected to at least 20/70.

Vision Care Exclusions

1. Lenses that do not require a prescription or sunglasses (plain or prescription). Glasses with a tint other than No. 1 or No. 2 will be considered sunglasses for the purpose of this exclusion.

2. Services and materials (a) in connection with non-surgical treatment or procedures, such as orthoptics and visual training; (b) received in a United States government Hospital, furnished elsewhere by or for the United States government, or provided by any government plan or law under which the individual is or could be covered; or (c) provided under workers' compensation benefits.

3. Replacement of lenses or frames which were furnished under the Plan and which have been lost, stolen, or broken.

4. Any procedure done to correct a refractive error, including surgeries such as LASIK and PRK.

One exam and two lenses per Calendar Year
One set of frames every 24 months

Vision Care

Maximum allowance

Exam……………………...$35
Frames……………………$30
Each lens:
Single vision……….……...$20
Bifocal………………...…..$35
Trifocal……………………$45
Lenticular…………………$50
Contact lenses…………....$100

Outside the United States

Medicare does not provide benefits when you are outside the United States or its territories and need medical attention or hospitalization for illness or injury. Therefore, you should pay the bill yourself and submit to Blue Shield of California a copy of the itemized bill along with a report from the attending Physician (written in English). You will then be reimbursed directly by the PERS Gold Supplemental Plan for Covered Services.

All requests for reimbursement must be submitted within fifteen (15) months from the date services were provided to:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927

Temporary Absence Outside the United States

When a Member incurs covered charges during the first six (6) months of a temporary absence outside the United States and its territories (unless provided in Canada or Mexico*), the PERS Gold Supplemental Plan will provide the benefits as described in the PERS Gold Basic Plan Benefit Booklet as though the Member incurring such charges were insured under that Plan. These benefits will include the PERS Gold Basic Plan Copayments and deductibles. You may obtain a copy of the PERS Gold Basic Plan Benefit Booklet by calling the Member Services Department at 800-405-2127.

If a Member is in the Hospital on the last day of the six (6) months' temporary absence outside the United States, benefits will be provided under the PERS Gold Basic Plan for the duration of the Hospital confinement or until the PERS Gold Basic Plan has paid Benefits that reach the Benefit maximum.

*Exception for Canadian and Mexican Hospitals. Medicare generally cannot pay for hospital or medical services outside the United States. But it can help pay for care in qualified Canadian or Mexican hospitals in three situations: (1) if you are in the U.S. when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest U.S. hospital that can provide the care you need; (2) if you live in the U.S. and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital which can provide the care you need, regardless of whether or not an emergency exists; or (3) if you are in Canada traveling by the most direct route to or from Alaska and another state and an emergency occurs which requires that you be admitted to a Canadian hospital (this provision does not apply if you are vacationing in Canada).

When Medicare hospital insurance (Part A) covers your Inpatient stay in a Canadian or Mexican hospital, your PERS Gold Supplemental Plan medical insurance can cover necessary Physician services and any required use of an ambulance.

Members Who Move Outside the United States

If you move, other than temporarily, outside the United States as defined in the Federal Social Security Act, you are no longer eligible for this Plan. You must change enrollment to a Basic Plan as Medicare does not provide benefits when you are permanently outside the United States. Please contact the Health Benefits Officer at your agency (actives) or the CalPERS Health Account Services Section (retirees) as soon as possible to enroll in a Basic Plan and to get a copy of the Basic Plan Benefit Booklet. Once you are enrolled under the Basic Plan, all applicable deductibles, Copayments, Benefit maximums, and exclusions described under the Basic Plan will apply. Any Benefits provided under this PERS Gold Supplemental Plan will no longer apply. You will need a copy of the Basic Plan Benefit Booklet in order to

determine what your medical Benefits are. You may also visit Blue Shield of California's website http://www.blueshieldca.com/calpers to access benefit information.

Exclusions and Limitations

General Exclusions and Limitations

Services covered under this PERS Gold Supplement to Original Medicare Plan must be covered by Medicare. Except for vision care benefits, hearing aid services, acupuncture services, chiropractic care and smoking cessation programs, any services or supplies that are not covered by Medicare are excluded under this Plan.

Unless exceptions to the following exclusions are specifically made elsewhere in the Agreement, no benefits are provided for services which are:

1. **Benefit Substitution/Flex Benefit/In Lieu Of.** Any program, treatment, service, or benefit cannot be substituted for another benefit or non-existing benefit. For example, a Member may not receive home health care benefits in lieu of an admission to a skilled nursing facility.

2. **Close Relative Services.** Services performed by a Close Relative or by a person who ordinarily resides in the Member's home.

3. **Coordination with Medicare Advantage Plans.** Copayments or any other charges that are part of a Medicare Advantage Plan are not covered under this Plan.

4. **Excess Charges.** Any expense incurred for services of a Physician or other health care provider in excess of Plan Benefits.

5. **Experimental or Investigational Procedures.** Experimental or Investigational practices, procedures, or products, and services in connection with such practices, procedures, or products. Costs incurred for any treatment or procedure deemed by the plan to be Experimental or Investigational are not covered.

6. **Government-Provided Services.** Any services provided by a local, state or federal government agency, unless reimbursement by this Plan for such services is required by state or federal law.

7. **Non-Listed Benefits.** Services not specifically listed as Benefits or not reasonably medically linked to or connected with listed Benefits, whether or not prescribed by a Physician or approved by Medicare.

8. **Self-injectable drugs.** Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or Family Member. Drugs with Food and Drug Administration (FDA) labeling for self-administration. Hypodermic syringes and/or needles when dispensed for use with self-injectable drugs or medications.

9. **Telephone, Facsimile Machine, and E-mail Consultations.** Telephone, facsimile machine, and electronic mail consultations for any purpose, whether between the Physician or other health care provider and the Member or Member's family, or involving only Physicians or other health care providers.

10. **Voluntary Payment of Non-Obligated Charges.** Services for which the Plan Member is not legally obligated to pay, or services for which no charge is made to the Plan Member in the absence of health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:
    a. It must be internationally known as being devoted mainly to medical research;

b. At least ten percent (10%) of its yearly budget must be spent on research not directly related to patient care;
c. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
d. It must accept patients who are unable to pay; and
e. Two-thirds of its patients must have conditions directly related to the hospital's research.

11. **War.** Conditions cause by war, whether declared or undeclared.

12. **Workers' Compensation/Work-Related Injury.** For or incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if Blue Shield of California provides payment for such services it will be entitled to establish a lien upon such other benefits up to the reasonable cash value of benefits provided by Blue Shield of California for the treatment of the injury or disease as reflected by the providers' usual billed charges.

See the Grievance Process section for information on filing a grievance and your rights to independent medical review.

Medical Necessity Exclusion

All services must be medically necessary. The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically necessary, even though it is not specifically listed as an exclusion or limitation. Blue Shield of California may limit or exclude benefits for services which are not medically necessary. This exclusion does not apply to services which Blue Shield of California is required by law to cover for Reconstructive Surgery.

Exception for Other Coverage

Medicare Providers may seek reimbursement from other third party payors for the balance of their reasonable charges for services rendered under this Plan.

Claims and Services Review

Blue Shield of California reserves the right to review all claims and services to determine if any exclusions or other limitations apply. Blue Shield of California may use the services of physician consultants, peer review committees of professional societies or hospitals and other consultants to evaluate claims.

General Provisions

Members Rights and Responsibilities

You, as a PERS Gold Supplement to Original Medicare PPO Plan Member, have the right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity;
2. Receive information about all health services available to you, including a clear explanation of how to obtain them;
3. Receive information about your rights and responsibilities;
4. Receive information about your Supplement to Original Medicare PPO Health Plan, the services we offer you, the physicians and other practitioners available to care for you;
5. Have reasonable access to appropriate medical services;
6. Participate actively with your physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment;
7. A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;
8. Receive from your physician an understanding of your medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment;
9. Receive Preventive Health Services when covered by Medicare;
10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living;
11. Have confidential health records, except when disclosure is required or permitted by state law (California) or federal law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your physician;
12. Communicate with and receive information from Member Services in a language you can understand;
13. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available;
14. Be fully informed about Blue Shield of California's grievance procedure and understand how to use it without fear of interruption of health care;
15. Voice complaints or grievances about the Supplement to Original Medicare PPO Health Plan or the care provided to you;
16. Make recommendations regarding Blue Shield of California's Member rights and responsibilities policy.

You, as a PERS Gold Supplement to Original Medicare PPO Plan Member, have the responsibility to:

General Provisions

1. Carefully read all Supplement to Original Medicare materials immediately after you are enrolled so you understand how to use your benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Supplement to Original Medicare membership as explained in the Benefit Booklet;

2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed;

3. Provide, to the extent possible, information that your physician, and/or the Plan need to provide appropriate care for you;

4. Understand your health problems and take an active role in making health care decisions with your medical care provider, whenever possible.

5. Follow the treatment plans and instructions you and your physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations;

6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given;

7. Make and keep medical appointments and inform your physician ahead of time when you must cancel;

8. Communicate openly with the physician you choose so you can develop a strong partnership based on trust and cooperation;

9. Offer suggestions to improve the Supplement to Original Medicare PPO Plan;

10. Help Blue Shield of California to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage;

11. Notify Blue Shield of California as soon as possible if you are billed inappropriately or if you have any complaints;

12. Treat all Plan personnel respectfully and courteously as partners in good health care;

13. Pay your Dues (Rates), copayments and charges for non-covered services on time;

14. For all Mental Health and Substance Use Disorder services, follow the treatment plans and instructions and obtain prior authorization for all non-emergency inpatient Mental Health and Substance Use Disorder services.

Confidentiality of Medical Records and Personal Health Information

Blue Shield of California protects the confidentiality/privacy of your personal health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. Blue Shield of California will not disclose this information without your authorization, except as permitted by federal law.

A STATEMENT DESCRIBING BLUE SHIELD OF CALIFORNIA'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Blue Shield of California's policies

and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices," which you may obtain either by calling the Member Services Department at the number listed on the back cover of this booklet, or by accessing Blue Shield of California's internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield of California may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence Address:
Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone:
1-888-266-8080

Email Address:
blueshieldca_privacy@blueshieldca.com

Access to Information

Blue Shield of California may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Agreement. You agree that any provider or entity can disclose to Blue Shield of California that information that is reasonably needed by Blue Shield of California. You agree to assist Blue Shield of California in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield of California with information in your possession. Failure to assist Blue Shield of California in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield of California will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Non-Assignability

Benefits of this Plan are not assignable.

Possession of a Member identification card confers no right to services or other benefits of this Agreement. To be entitled to services, the Member must be a Participant who has been enrolled by Blue Shield of California and who has maintained enrollment under the terms of this Agreement.

Preferred Providers are paid directly by Blue Shield of California. The Member or the provider of service may not request that payment be made directly to any other party.

Independent Contractors

Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts or omissions of any person receiving or providing services, including any physician, hospital, or other provider or their employees.

General Provisions

Web Site

Blue Shield of California's Web site is located at http://www.blueshieldca.com. Members with Internet access and a Web browser may view and download health care information.

Utilization Review Process

To request a copy of the document describing this Utilization Review, call the Member Services Department at 800-405-2127.

Medical Claims Review and Appeals Process

The procedures outlined below are designed to ensure you have a full and fair consideration of claims submitted to the Plan.

The following procedures shall be used to resolve any dispute which results from any act, failure to act, error, omission or medical judgment determination by Blue Shield of California's review with respect to any medical claim filed by you or on your behalf. The procedures should be followed carefully and in the order listed.

Please refer to your PDP EOC for the Pharmacy Appeal Process.

The cost of copying and mailing medical records required for Blue Shield of California to review its determination is your or your Authorized Representative's responsibility.

Medicare Denied Claims

1. **Notice of Claim Denial**

   This Plan supplements the benefits paid by Medicare. If a medical claim has been denied by Medicare, the supplemental payment through this Plan will also be denied, as secondary payment by this Plan is dependent upon Medicare's primary payment. Blue Shield of California will notify you of such denial in writing. This notice shall contain the reason for the denial.

2. **Claim Denial due to Medicare Denial**

   You must appeal the Medicare determination with Medicare if the Medicare claim is denied. Your appeal rights are detailed on the back of the Medicare Summary Notice form that is mailed to you. If, after the appeal process is completed, you receive notification from Medicare that the claim has been paid, this Plan will pay any covered supplemental benefits.

Claim Denials for Benefits Beyond Medicare

1. Objection to Claim Processing

You or your Authorized Representative may object by writing to the Member Services Department within one hundred eighty (180) days of the discovery of any act, failure to act, error, or omission with regard to a properly submitted claim. The objection must set forth all reasons in support of the proposition that an act with regard to the claim, failure to act on the claim, error, or omission occurred. The objection should be sent to:

Blue Shield of California
Customer Service Appeals and Grievance
P.O. Box 5588
El Dorado Hills, CA 95762
Telephone: 800-405-2127
Website: http://www.blueshieldca.com

Blue Shield of California will acknowledge receipt of the objection by written notice to you and/or your Authorized Representative within five (5) days of receipt of the objection. Blue Shield of California will then either affirm its decision regarding the claim, take action on the claim or resolve the error or omission within thirty (30) days of receipt of the objection.

If Blue Shield of California affirms its decision regarding the claim or fails to respond within thirty (30) days after receiving the request for review, and you and/or your Authorized Representative still objects to Blue Shield of California's act, failure to act, error, or omission as stated above, you and/or your Authorized Representative may proceed to Administrative Review as outlined in item 6. below.

2. Notice of Claim Denial – Adverse Benefit Determination (ABD)

In the event any claim for Benefits Beyond Medicare is denied, in whole or in part, Blue Shield of California will notify you and/or your Authorized Representative of such denial in writing within 30 days. Any denial of a claim for benefits is considered an "adverse benefit determination" (ABD) and can be based on the fact that it is not a covered benefit, the treatment is not Medically Necessary, or the treatment is Experimental/Investigational. The denial can be the result of Utilization Review for a prospective service, a service that is currently being pursued, or a service that has already been provided. The ABD shall contain specific reasons for the denial and an explanation of the Plan's review and appeal procedure. Any ABD is subject to Internal Review upon request.

3. Internal Review

You and/or your Authorized Representative may request a review of an ABD by writing or calling the Member Services Department within one hundred and eighty (180) days of receipt of an ABD. Your appeal or grievance must clearly state your issue, such as the reasons you disagree with the ABD or why you are dissatisfied with the Services you received. If you would like Blue Shield of California to consider your grievance on an urgent basis, please write "urgent" on the request and provide the rationale. (See definition of "Urgent Review" below.) Requests for review should be sent to:

Blue Shield of California
Customer Service Appeals and Grievance
P.O. Box 5588
El Dorado Hills, CA 95762
Telephone: 800-405-2127
Website: http://www.blueshieldca.com

You and/or your Authorized Representative may submit written comments, documents, records, scientific studies, and other information relating to the claim that resulted in an ABD in support of the request for Internal Review. You and/or your Authorized Representative will be provided, upon request and free of charge, reasonable access to records and other information relevant to your claim for benefits, including the right to review the claim file and submit evidence.

Blue Shield of California will acknowledge receipt of a request for Internal Review by written notice to you and/or your Authorized Representative within five (5) business days. Blue Shield of California will then either uphold or reject the ABD within thirty (30) days of the request for Internal Review if it involves an authorization of services (pre-service appeal or concurrent appeal) or within sixty (60) days for services that have already been provided (post-service appeal).

If Blue Shield of California upholds the ABD within the timeframes described above, that decision becomes a "Final Adverse Benefit Determination" (FABD), and you may pursue the independent External Review process described in section 5. below.

4. Urgent Review

An urgent appeal is resolved within 72 hours upon receipt of the request, but only if Blue Shield of California determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; OR

- The standard appeal timeframe would, in the opinion of a Physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending their course of covered treatment; OR

- A Physician with knowledge of your medical condition determines that their grievance is urgent.

If Blue Shield of California determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request. If your situation is subject to an urgent review, you and/or your Authorized Representative can simultaneously request an independent External Review described below.

5. Request for Independent External Review

If the FABD includes a decision based on Medical Judgment, the FABD will include the Plan's standard for Medical Necessity or other Medical Judgment related to that determination, and describe how the treatment fails to meet the Plan's standard. You and/or your Authorized Representative will be notified that you may request an independent External Review of that determination by an Independent Review Organization (IRO). This review is at no cost to you. Examples of Medical Judgment include, but are not limited to:

- The appropriate health care setting for providing medical care to an individual (such as outpatient versus Inpatient care or home care versus rehabilitation facility); or

- Whether treatment by a specialist is Medically Necessary or appropriate pursuant to the Plan's standard for Medical Necessity or appropriateness; or

- Whether treatment involved "emergency care" or "urgent care", affecting coverage or the level of coinsurance.

You and/or your Authorized Representative may request an independent External Review no later than four (4) months from the date of receipt of the FABD. The type of services in dispute must be a covered benefit. For cases involving Medical Judgment, you and/or your Authorized Representative must exhaust the independent External Review prior to requesting a CalPERS Administrative Review. (See the CalPERS Administrative Review and Administrative Hearing section.)

You and/or your Authorized Representative may also request an independent External Review if Blue Shield of California fails to render a decision within the timelines specified above in 3. for Internal Review. For a more complete description of independent External Review rights, please see 45 Code of Federal Regulations section 147.136.

6. Request for CalPERS Administrative Review Process

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions and the independent External Review in cases involving Medical Judgment, you and/or your Authorized Representative may request a CalPERS Administrative Review. You and/or your Authorized Representative may also request Administrative Review in connection with an objection to the processing of a claim by

Medical Claims Review and Appeals Process

Blue Shield of California. Only claim denials for Benefits Beyond Medicare are eligible for Administrative Review. Please see section 1. above.

CalPERS Administrative Review and Administrative Hearing

1. Administrative Review

If you remain dissatisfied with Blue Shield of California's determination or the independent external review determination, the Member may request an Administrative Review. The Member must exhaust Blue Shield of California's internal grievance process and the independent external review process, when applicable, prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of the FABD or the independent external review determination letter. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Review, not to exceed 30 days.

The request must be mailed to:

> CalPERS Health Benefits Compliance & Appeals Unit
> Health Appeals Coordinator
> P.O. Box 1953
> Sacramento, CA 95812-1953

The Member is encouraged to include a signed Authorization to Release Health Information (ARHI) form in the request for an Administrative Review, which gives permission to the Plan to provide medical documentation to CalPERS. If the Member would like to designate an Authorized Representative to represent him/her in the Administrative Review process, complete Section IV. Election of Authorized Representative on the ARHI form. The Member must complete and sign the form. An ARHI assists CalPERS in obtaining health information needed to make a decision regarding a Member's request for Administrative Review. The ARHI form will be provided to the Member with the FABD letter from Blue Shield of California. If the Member has additional medical records from Providers or scientific studies that the Member believes are relevant to CalPERS review, those records should be included with the written request. The Member should send copies of documents, not originals, as CalPERS will retain the documents for its files. The Member is responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) calendar days from the date all pertinent information is received by CalPERS.

2. Administrative Hearing

The Member must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

The Member must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing good cause, CalPERS may grant additional

time to file a request for an Administrative Hearing, not to exceed 30 days. The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to a member's case not previously submitted for Administrative Review and independent external review.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); the Member may, but is not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to the Member within two weeks of the Board's open meeting.

3. Appeal Beyond Administrative Review and Administrative Hearing

If the Member is still dissatisfied with the Board's decision, the Member may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

A Member may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act

- **Right to records, generally.** The Member may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- **Attorney Representation.** At any stage of the appeal proceedings, the Member may be represented by an attorney. If the Member chooses to be represented by an attorney, the Member must do so at his or her own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse the Member for the cost of an attorney even if the Member prevails on appeal.
- **Right to experts and consultants.** At any stage of the proceedings, the Member may present information through the opinion of an expert, such as a physician. If the Member chooses to retain an expert to assist in presentation of a claim, it must be at the Member's own expense. Neither CalPERS nor the administrator will reimburse the Member for the costs of experts, consultants or evaluations.

Service of Legal Process
Legal process or service upon CalPERS must be served in person at:

CalPERS Legal Office
Lincoln Plaza North
400 "Q" Street Sacramento, CA 95814

If you are covered by Medicare and Medicare has made a decision regarding your appeal of a Medicare claim determination, you cannot appeal the Medicare decision through the CalPERS Board of Administration.

Continuation of Coverage

Termination of Benefits

Coverage for you or your dependents terminates at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the group Agreement is discontinued, (2) the last day of the month in which the Participant's employment terminates, unless a different date has been agreed to between Blue Shield of California and your employer, (3) the end of the period for which the premium is paid, or (4) the last day of the month in which you or your dependents become ineligible. A spouse also becomes ineligible following legal separation from the Participant, entry of a final decree of divorce, annulment or dissolution of marriage from the Participant. A domestic partner becomes ineligible upon termination of the domestic partnership.

Except as specifically provided under the Continuity of Care and COBRA provisions, there is no right to receive benefits for services provided following termination of this group Agreement.

If you cease work because of retirement, disability, leave of absence, temporary layoff or termination, see your employer about possibly continuing group coverage. Also, see the COBRA provisions described in this booklet for information on continuation of coverage.

Reinstatement

If you cancel or your coverage is terminated, refer to the CalPERS "Health Program Guide."

Cancellation

No benefits will be provided for services rendered after the effective date of cancellation, except as specifically provided under the Continuity of Care and COBRA provisions in this booklet.

The group Agreement also may be cancelled by CalPERS at any time provided written notice is given to Blue Shield of California to become effective upon receipt, or on a later date as may be specified on the notice. Information pertaining to cancellation can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS.

COBRA

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

If a Member is entitled to elect continuation of group coverage under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, the following applies:

The COBRA group continuation coverage is provided through federal legislation and allows an enrolled active or retired employee or his/her enrolled family member who lose their regular group coverage because of certain "qualifying events" to elect continuation for 18, 29, or 36 months.

An eligible active or retired employee or his/her family member(s) is entitled to elect this coverage provided an election is made within 60 days of notification of eligibility and the required premiums are paid. The benefits of the continuation coverage are identical to the group plan and the cost of coverage shall be 102% of the applicable group premiums rate. No employer contribution is available to cover the premiums.

Continuation of Coverage

Two "qualifying events" allow enrollees to request the continuation coverage for 18 months. The Member's 18-month period may also be extended to 29 months if the Member was disabled on or before the date of termination or reduction in hours of employment, or is determined to be disabled under the Social Security Act within the first 60 days of the initial qualifying event and before the end of the 18-month period (non-disabled eligible family members are also entitled to this 29-month extension).

1. The covered employee's separation from employment for reasons other than gross misconduct.

2. Reduction in the covered employee's hours to less than half-time.

Four "qualifying events" allow an active or retired employee's enrolled family member(s) to elect the continuation coverage for up to 36 months. Children born to or placed for adoption with the Member during a COBRA continuation period may be added as dependents, provided the employer is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption.

1. The employee's or retiree's death (and the surviving family member is not eligible for a monthly survivor allowance from CalPERS).

2. Divorce or legal separation of the covered employee or retiree from the employee's or retiree's spouse or termination of the domestic partnership.

3. A dependent child ceases to be a dependent child.

4. The primary COBRA Participant becomes entitled to Medicare.

If elected, COBRA continuation coverage is effective on the date coverage under the group plan terminates.

The COBRA continuation coverage will remain in effect for the specified time, or until one of the following events terminates the coverage:

1. The termination of all employer provided group health plans, or

2. The enrollee fails to pay the required premium(s) on a timely basis, or

3. The enrollee becomes covered by another health plan without limitations as to pre-existing conditions, or

4. The enrollee becomes eligible for Medicare benefits, or

5. The continuation of coverage was extended to 29 months and there has been a final determination that the Member is no longer disabled.

You will receive notice from your employer of your eligibility for COBRA continuation coverage if your employment is terminated or your hours are reduced.

Contact your (former) employing agency or CalPERS directly if you need more information about your eligibility for COBRA group continuation coverage.

Payment by Third Parties

Third Party Recovery Process and the Member's Responsibility

If a Member's injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no benefits will be payable under the Plan unless you agree in writing, in a form satisfactory to the plan, to do all of the following:

1. Provide the Plan with a written notice of any claim made against the third party for damages as a result of the injury or illness;

2. Agree in writing to reimburse the Plan for benefits paid by the Plan from any recovery (defined below) when the recovery is obtained from or on behalf of the third party or the insurer of the third party, or from the Member's uninsured or underinsured motorist coverage;

3. Execute a lien in in favor of the Plan for the full amount of benefits paid by the Plan;

4. Ensure that any recovery is kept separate from and not comingled with any other funds and agree in writing that the portion of any recovery required to satisfy the lien of the Plan is held in trust for the sole benefit of the Plan until such time it is conveyed to the plan;

5. Periodically respond to information requests regarding the claim against the third party, and notify the Plan, in writing, within 10 days after any recovery has been obtained;

6. Direct any legal counsel retained by the Member or any other person acting on the Member's behalf to hold that portion of the recovery to which the Plan is entitled in trust for the sole benefit of the Plan and to comply with and facilitate the reimbursement to the Plan of the monies owed it.

If the Member fails to comply with the above requirements, no benefits will be paid with respect to the injury or illness. If benefits have been paid, they may be recouped by the Plan, through deductions from future benefit payments to the Member or others enrolled through the Member in the plan.

"Recovery" includes any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from your uninsured or underinsured motorist coverage, related to the illness or injury, without reduction for any attorneys' fees paid or owed by the you or on your behalf, and without regard to whether you have been "made whole" by the Recovery. Recovery does not include monies received from any insurance policy or certificate issued in your name, except for uninsured or underinsured motorist coverage. The Recovery includes all monies received, regardless of how held, and includes monies directly received as well as any monies held in any account or trust on your behalf, such as an attorney-client trust account.

You shall pay to the Plan from the Recovery an amount equal to the Benefits actually paid by the Plan in connection with the illness or injury. If the Benefits paid by the Plan in connection with the illness or injury exceed the amount of the Recovery, you shall not be responsible to reimburse the Plan for the Benefits paid in connection with the illness or injury in excess of the Recovery.

Your acceptance of Benefits from the Plan for illness or injury caused by a third party shall act as a waiver of any defense to full reimbursement of the Plan from the Recovery, including any defense that the injured individual has not been "made whole" by the Recovery or that the individual's attorneys' fees and costs, in whole or in part, are required to be paid or are payable from the Recovery, or that the Plan should pay a portion of the attorneys' fees and costs incurred in connection with the claims against the third party.

Payment by Third Parties

THE FOLLOWING LANGUAGE APPLIES UNLESS THE PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"); IF THE PLAN IS SUBJECT TO ERISA, THE FOLLOWING LANGUAGE DOES NOT APPLY.

If you receive services from a Participating Hospital for injuries or illness, the Hospital has the right to collect from you the difference between the amount paid by the Plan and the Hospital's reasonable and necessary charges for such services when you receive payment or reimbursement for medical expenses.

Workers' Compensation

No benefits are provided for or incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation.

However, if Blue Shield of California provides payment for such services it will be entitled to establish a lien upon such other benefits up to the reasonable cash value of benefits provided by Blue Shield of California for the treatment of the injury or disease as reflected by the providers' usual billed charges.

Coordination of Benefits

When a Member who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of or reimbursement for hospital or medical expenses, such Member will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual value or cost during any calendar year.

Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit value or amount payable by each plan separately.

If the Member is also entitled to benefits under any of the conditions as outlined under the Limitations for Duplicate Coverage provision, benefits received under any such condition will not be coordinated with the benefits of this Plan. The following rules determine the order of benefit payments:

When the other plan does not have a coordination of benefits provision, it will always provide its benefits first. Otherwise, the plan covering the patient as an employee will provide its benefits before the plan covering the patient as a dependent.

Except for cases of claims for a dependent child whose parents are separated or divorced, the plan which covers the dependent child of a Member whose date of birth (excluding year of birth) occurs earlier in a calendar year, shall determine its benefits before a plan which covers the dependent child of a Member whose date of birth (excluding year of birth) occurs later in a calendar year. If either plan does not have the provisions of this paragraph regarding dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits.

1. In the case of a claim involving expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent shall determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried,

the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

2. Notwithstanding 1. above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a dependent of the parent with that financial responsibility shall determine its benefits before any other plan which covers the child as a dependent child.

3. If the above rules do not apply, the plan which has covered the patient for the longer period of time shall determine its benefits first, provided that:

   a. A plan covering a patient as a laid-off or retired employee, or as a dependent of such an employee, shall determine its benefits after any other plan covering that Member as an employee, other than a laid-off or retired employee, or such dependent; and,

   b. If either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the provisions of a. above shall not apply.

If this Plan is the primary carrier with respect to a Member, then this Plan will provide its benefits without reduction because of benefits available from any other plan.

When this Plan is secondary in the order of payments, and Blue Shield of California is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will provide the benefits that would be due as if it were the primary plan, provided that the Member: (1) assigns to Blue Shield of California the right to receive benefits from the other plan to the extent of the difference between the value of the benefits which Blue Shield of California actually provides and the value of the benefits that Blue Shield of California would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully with Blue Shield of California in obtaining payment of benefits from the other plan, and (3) allows Blue Shield of California to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

If payments which should have been made under this Plan in accordance with these provisions have been made by another Plan, Blue Shield of California may pay to the other Plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as benefits paid under this Plan. Blue Shield of California shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by Blue Shield of California in excess of the maximum amount of payment necessary to satisfy these provisions, Blue Shield of California shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

Blue Shield of California may release to or obtain from any organization or person any information which Blue Shield of California considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other Plan. Any person claiming benefits under this Plan shall furnish Blue Shield of California with such information as may be necessary to implement these provisions.

Claims

After Medicare's benefits have been exhausted and you receive health care services for a "Benefit Beyond Medicare," a claim must be submitted to request payment for Covered Services.

When you see a Medicare Provider, your provider submits the claim to Blue Shield of California. When you see a Non-Preferred Provider, you must submit the claim to Blue Shield of California. Claim forms are available at blueshieldca.com.

How to Submit a Claim

Please submit a medical services claim, including Blue Shield of California claim form and the itemized bill from your provider, to:

> Blue Shield of California
> P.O. Box 272540
> Chico, CA 95927

Please submit a vision services claim, including the itemized bill from your provider, to:

> Vision Plan Administrator
> Attn: OON Claims
> P.O. Box 8504
> Mason, OH 45040-7111

All claims are due within one year of the service date.

Claim processing and payments

Blue Shield of California will process your claim within 30 business days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. Blue Shield of California cannot process your claim until we receive the missing information.

Once your claim is processed, you will receive an explanation of your Benefits. For each service, the explanation will list your Cost Share and the payment made by Blue Shield of California to the provider.

When you receive Covered Services from a Non-Preferred Provider, Blue Shield of California may send the payment to the Participant, or directly to the Non-Preferred Provider.

Note: The Participant must make sure the Non-Preferred Provider receives the full billed amount for non-emergency services, whether or not Blue Shield of California makes payment to the Non-Preferred Provider.

Monthly Rates

State Employees and Annuitants

The Rates shown below are effective January 1, 2025 and will be reduced by the amount the State of California contributes toward the cost of your health benefit plan. These contribution amounts are subject to change as a result of collective bargaining agreements or legislative action. Any such change will be accomplished by the State Controller or affected retirement system without any action on your part. For current contribution information, contact your employing agency or retirement system health benefits officer.

Cost of the Program

Type of Enrollment	Monthly Rate
Employee only	$546.13
Employee and one dependent	$1,092.26
Employee and two or more dependents	$1,638.39

Contracting Agency Employees and Annuitants

The Rates shown above are effective January 1, 2025 and will be reduced by the amount your contracting agency contributes toward the cost of your health benefit plan. This amount varies among public agencies. For assistance calculating your net contribution, contact your agency or retirement system health benefits officer.

Rate Change

The plan Rates may be changed as of January 1, 2026, following at least 60 days' written notice to the Board prior to such change.

Definitions

Accidental Injury - definite trauma resulting from a sudden unexpected and unplanned event, occurring by chance, caused by an independent external source.

Activities of Daily Living (ADL) - the self-care and mobility skills required for independence in normal everyday living. This does not include recreational or sports activities.

Acute Care - care rendered in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and which is not expected to last indefinitely.

Adverse Benefit Determination (ABD) - a decision by Blue Shield of California to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Determination of an individual's eligibility to participate in this PPO plan; or
- Determination that a benefit is not covered; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Adverse Childhood Experiences - An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

Agreement - see Plan Document.

Allowable Amount – Blue Shield of California's allowance as defined below for the service(s) rendered, or the provider's billed charge, whichever is less. The allowance is:

1. the amount Blue Shield of California has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based upon such factors as the PERS Platinum Supplemental Plan's evaluation of the value of the service(s) relative to the value of other services, market considerations, and provider charge patterns; or

2. such other amount as the Preferred Provider and Blue Shield of California have agreed will be accepted as payment for the service(s) rendered; or

3. if an amount is not determined as described in either (1) or (2) above, the amount that Blue Shield of California determines is appropriate considering the particular circumstances and the services rendered.

Alternate Care Services Provider - durable medical equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

Appeal – complaint regarding (1) payment has been denied for services that you already received, or (2) a medical provider, or (3) your coverage under this EOC, including an Adverse Benefit Determination as set forth under the ACA (4) you tried to get prior authorization to receive a service and were denied, or (5) you disagree with the amount that you must pay.

Authorized Representative - means an individual designated by the Member to receive Protected Health Information about the Member for purposes of assisting with a claim, an Appeal, a Grievance or other matter. The Authorized Representative must be designated by the Member in writing on a form approved by Blue Shield of California.

Definitions

Benefits (Covered Services) - those services which a Member is entitled to receive pursuant to the terms of the Group Health Service Agreement.

Calendar Year - a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. January 1 of the following year.

Christian Science Nurse - A Christian Science Nurse approved as such by The First Church of Christ Scientist, in Boston, Massachusetts and listed in the Christian Science Journal.

Christian Science Nursing Facility - A Christian Science Nursing Facility accredited by The Commission for Accreditation of Christian Science Nursing Organization/Facilities, Inc.

Christian Science Practitioner - Christian Science Practitioner approved as such by The First Church of Christ Scientist, in Boston, Massachusetts, and listed in the Christian Science Journal.

Claims Administrator - The claims payor designated by the Employer to adjudicate claims and provide other services as mutually agreed. Blue Shield of California has been designated the Claims Administrator.

Close Relative - the spouse, domestic partner, child, brother, sister or parent of a Member.

Copayment - the amount that a Member is required to pay for specific covered services.

Covered Services (Benefits) - those services which a Member is entitled to receive pursuant to the terms of the Group Health Service Agreement.

Custodial or Maintenance Care - care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board or meet the Activities of Daily Living (which may include nursing care, training in personal hygiene and other forms of self-care or supervisory care by a physician); or care furnished to a Member who is mentally or physically disabled, and

1. who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or,

2. when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Doctor of Medicine - a licensed Medical Doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.).

Dues (Rates) - the monthly prepayment that is made to the Plan on behalf of each Member by the Contractholder.

Durable Medical Equipment - equipment designed for repeated use which is medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable medical equipment includes wheelchairs, hospital beds, respirators, required dialysis equipment and medical supplies, and other items that the Plan determines are durable medical equipment.

Emergency Medical Condition - a medical condition, including a psychiatric emergency, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that you reasonably believe the absence of immediate medical attention could result in any of the following:

1) placing your health in serious jeopardy (including the health of a pregnant woman or her unborn child);

2) serious impairment to bodily functions;

3) serious dysfunction of any bodily organ or part;

4) danger to yourself or to others; or

5) inability to provide for, or utilize, food, shelter, or clothing, due to a mental disorder.

Emergency Services – the following services for an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition,

2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to stabilize the Member.

3) Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general Acute Care Hospital or to an acute psychiatric Hospital; and

4) Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the plan and furnished by a Non-Preferred Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of outpatient observation or inpatient or outpatient stay.

'Stabilize' means to provide medical treatment of the condition as may be necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another Hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Post-Stabilization Care means Medically Necessary services received after the treating Physician determines the Emergency Medical Condition is stabilized.

Employer (Contractholder) - means any person, firm, proprietary or non-profit corporation, partnership, public agency or association that has at least 101 employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for the purposes of buying health care coverage or insurance.

Experimental or Investigational in Nature - any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies shall be considered Experimental or Investigational if, as determined by Blue Shield of California, at least one of the following elements is met:

1. Requires approval by the federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered; or

2. Is not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue, but nevertheless is authorized by law or by a government agency for use; or
3. Is not approved or recognized in accordance with accepted professional medical standards, but nevertheless is authorized by law or by a government agency for use in testing, trials, or other studies on human patients; or
4. Is not recognized or not recommended by nationally recognized treatment guidelines by a specialty society or medical review organization, if applicable; or
5. Where the consensus amongst experts in recognized published medical literature is that further studies, research, or experience is necessary to determine effectiveness and net health benefit in the treatment of the illness, injury, or condition at issue, but nevertheless is authorized by law or by a government agency for use.

Family - the Participant and all enrolled dependents.

Grievance – complaint regarding dissatisfaction with the care or services that you received from your plan or some other aspect of the plan.

Health Care Provider - An appropriately licensed or certified professional who provides health care services within the scope of that license, including, but not limited to: acupuncturist; associate clinical social worker; associate marriage and family therapist or marriage and family therapist trainee; associate professional clinical counselor or professional clinical counselor trainee; audiologist; board certified behavior analyst (BCBA); certified nurse midwife; chiropractor; clinical nurse specialist; dentist; hearing aid supplier; licensed clinical social worker; licensed midwife; licensed professional clinical counselor (LPCC); licensed vocational nurse; marriage and family therapist; massage therapist; naturopath; nurse anesthetist (CRNA); nurse practitioner; occupational therapist; optician; optometrist; pharmacist; physical therapist; physician; physician assistant; podiatrist; psychiatric/mental health registered nurse; psychologist; psychology trainee or person supervised as required by law; qualified autism service provider or qualified autism service professional certified by a national entity; registered dietician; registered nurse; registered psychological assistant; registered respiratory therapist; speech and language pathologist.

Hospice or Hospice Agency - an entity which provides hospice services to terminally ill persons and holds a license, currently in effect as a hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

Hospital - either 1., 2. or 3. below:

1. a licensed and accredited health facility which is primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an inpatient basis, and which provides such facilities under the supervision of a staff of physicians and 24 hour a day nursing service by registered nurses. A facility which is principally a rest home, nursing home or home for the aged is not included; or,

2. a psychiatric hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations; or,

3. a "psychiatric health facility" as defined in Section 1250.2 of the Health & Safety Code.

Definitions

Incurred - a charge shall be deemed to be "incurred" on the date the particular service which gives rise to it is provided or obtained.

Inpatient - an individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

Medical Necessity (Medically Necessary) -

1. Benefits are provided only for services which are medically necessary.

2. Services which are medically necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury or medical condition, and which, as determined by Blue Shield of California, are:

   a. consistent with Blue Shield of California's medical policy; and,

   b. consistent with the symptoms or diagnosis; and,

   c. not furnished primarily for the convenience of the patient, the attending physician or other provider;

   d. furnished at the most appropriate level which can be provided safely and effectively to the patient: and,

   e. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

3. Hospital inpatient services which are medically necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a physician's office, the Outpatient Department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

4. Inpatient services which are not medically necessary include hospitalization:

   a. for diagnostic studies that could have been provided on an outpatient basis; or,

   b. for medical observation or evaluation; or,

   c. for personal comfort; or,

   d. in a pain management center to treat or cure chronic pain; or

   e. for Inpatient Rehabilitative Services that can be provided on an outpatient basis.

5. Blue Shield of California reserves the right to review all services to determine whether they are medically necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

This definition does not apply to Mental Health and Substance Use Disorders. Medically Necessary Treatment of a Mental Health or Substance Use Disorder is defined separately.

Medicare - refers to the programs of medical care coverage set forth in Title XVIII of the Social Security Act as amended by Public Law 89-97 or as thereafter amended.

Definitions

Medicare Limiting Amount - refers to a federally mandated maximum amount a provider can charge a Member for Covered Services if the provider does not accept Medicare assignment. This amount cannot exceed 15% more than Medicare's approved amount.

Member - an employee, annuitant, or family member as those terms are defined in Sections 22760, 22772 and code 22775 and domestic partner as defined in Sections 22770 and 22771 of the Government code.

Mental Health and Substance Use Disorder(s) - A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases or listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Non-Preferred Provider - any provider who has not contracted with Blue Shield of California to accept Blue Shield of California's payment, plus any applicable copayment or amount in excess of specified benefit maximums, as payment in full for covered services.

Occupational Therapy - treatment under the direction of a physician and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Orthosis - an orthopedic appliance or apparatus used to support, align, prevent or correct deformities or to improve the function of movable body parts.

Outpatient - an individual receiving services but not as an inpatient.

Outpatient Department of a Hospital — any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.

Participant - the person enrolled who is responsible for payment of premiums to the plan, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this plan.

Participating Provider - a physician, a hospital, an ambulatory surgery center, an Alternate Care Services Provider, or a home health care and home infusion agency that has contracted with Blue Shield of California to furnish services and to accept Blue Shield of California's payment, plus applicable copayments, as payment in full for covered services.

Physical Therapy - treatment provided by a physician or under the direction of a physician and provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician - a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

Plan - the PERS Gold Supplement to Original Medicare PPO Health Plan and/or Blue Shield of California.

Definitions

Plan Document - the document adopted by CalPERS that establishes the services that Participants and Dependents are entitled to receive under the Plan.

Preferred Provider - a Medicare Provider, a preferred hospital, or a Participating Provider.

Preventive Health Services — mean those primary preventive medical covered services provided by a physician, including related laboratory services, for early detection of disease as specifically listed below:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

2. Immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Includes immunizations required for travel and immunizations, such as Hepatitis B, for individuals at occupational risk;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

4. Adverse Childhood Experiences screenings;

5. With respect to women, such additional preventive care and screenings not described in paragraph 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive health services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered preventive health services is available in Blue Shield of California's Preventive Health Guidelines.
The Guidelines are available at http://www.blueshieldca.com/preventive or by calling Member Services and requesting that a copy be mailed to you.

In the event there is a new recommendation or guideline in any of the resources described in paragraphs 1. through 4. above, the new recommendation will be covered as a preventive health service no later than 12 months following the issuance of the recommendation. However, for COVID-19 Preventive Health Services and Preventive Health Services for a disease for which the Governor of the State of California has declared a public health emergency, a new recommendation will be covered within 15 business days.

Prosthesis - an artificial part, appliance or device used to replace or augment a missing or impaired part of the body.

Rates (Dues) - the monthly prepayment that is made to the Plan on behalf of each Member by the Contractholder.

Reconstructive Surgery - surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: (1) to improve function, or (2) to create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of this surgery for cleft palate procedures.

Definitions

Rehabilitative Services– inpatient or outpatient care furnished to an individual disabled by injury or illness, including severe mental illnesses, in order to develop or restore an individual's ability to function to the maximum extent practical. Rehabilitative Services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy. Benefits for Speech Therapy are described in Speech Therapy in the Benefit Descriptions section.

Respiratory Therapy - treatment, under the direction of a physician and provided by a certified respiratory therapist, to preserve or improve a patient's pulmonary function.

Services - includes medically necessary health care services and medically necessary supplies furnished incident to those services.

Skilled Nursing Facility - a facility with a valid license issued by the California Department of Health Services as a "skilled nursing facility" or any similar institution licensed under the laws of any other state, territory, or foreign country.

Speech Therapy - treatment under the direction of a physician and provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient's vocal skills which have been impaired by diagnosed illness or injury.

Supplement to Original Medicare Plan - refers to the supplement of Medicare services by a Preferred Provider Organization (PPO). Medicare coordinated care plans cover Medicare deductibles and coinsurance charges when services are preauthorized or obtained from Medicare Providers. Members are not restricted to the PPO network to receive covered Medicare services. However, if services are not received through the PPO plan, the services and charges will not be covered by Blue Shield of California.

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws, and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007

El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language Access Services

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiįį' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Đểđược hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾੱਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ)៖ សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا، تفضل بالاتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສຳລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

Notes

This Benefit Booklet should be retained for your future reference as a Member of this PPO plan.

Should you have any questions, please call Member Services at 800-405-2127.

PERS *Gold*

Health Plan Research and Administration Division
Self-Funded Health Plans
California Public Employees' Retirement System

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